Accrediting Organizations and Quality Improvement

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Abstract

This paper reviews the various organizations in the United States that perform accreditation and establish standards for healthcare delivery. These agencies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the American Medical Accreditation Program (AMAP), the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC), and the Accreditation Association for Ambulatory HealthCare (AAAHC). In addition, the Foundation for Accountability (FACCT) and the Agency for Healthcare Research and Quality (AHRQ) play important roles in ensuring the quality of healthcare. Each of the accrediting bodies is unique in terms of their mission, activities, compositions of their boards, and organizational histories, and each develops their own accreditation process and programs and sets their own accreditation standards. For this reason, certain accrediting organizations are better suited than others to perform accreditation for a specific area in the healthcare delivery system. The trend toward outcomes research is noted as a clear shift from the structural and process measures historically used by accrediting agencies. Accreditation has been generally viewed as a desirable process to establish standards and work toward achieving higher quality care, but it is not without limitations. Whether accrediting organizations are truly ensuring high quality healthcare across the United States is a question that remains to be answered.

(Am J Manag Care 2000;6:1117-1130)

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Accreditation of healthcare organizations has been viewed as a useful means of establishing national standards to help reduce variations in medical practice,[1-3] eliminate some medically inappropriate care,[4] and decrease some cost escalation. As defined by Rooney and van Ostenberg, accreditation is "a formal process by which a recognized body, usually a non-governmental organization..., assesses and recognizes that a healthcare organization meets applicable predetermined and published standards."[5]

About 95% of contracts made by managed care companies in the United States are with accredited hospitals,[6] indicating that managed care organizations consider accreditation a prerequisite to contracting with hospitals. Facilities other than hospitals, such as home health agencies and hospices, also feel pressured to become accredited. If an organization does not go through an accreditation process, it may indicate that the facility is not open to external evaluation of its performance.[6] The process of performing accreditation requires resources and time, which are not always at the disposal of all managed care companies and small healthcare agencies. Therefore, external organiza-

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tions are needed to efficiently and effectively perform this important task.

The following organizations perform the major accreditation and quality improvement functions in the United States: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the American Medical Accreditation Program (AMAP), the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC), and the Accreditation Association for Ambulatory HealthCare (AAAHC) (Table 1). Individual discussions of each of these organizations follow.

··· JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS ···

Mission

"The mission of the JCAHO is to improve the quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in healthcare organizations."[7]

History

The American College of Surgeons developed the "Minimum Standard for Hospitals" in 1917. In 1951, the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association joined with the American College of Surgeons to create the Joint Commission on Accreditation of Hospitals (JCAH). The Canadian Medical Association withdrew from the JCAH in 1959. After the Medicare Act was passed in 1965, hospitals accredited by the JCAH were "deemed" to be in compliance with most federal standards and consequently could participate in Medicare and Medicaid reimbursement.[8] In 1971, the JCAH established the Accreditation Council for Long-Term Care, and accreditation for ambulatory care began in 1975. The American Dental Association became a corporate member of the JCAH in 1979. Quality Healthcare Resources, Inc, was formed as a not-for-profit consulting subsidiary of the JCAH in 1986.[8] It is now known under the name Joint Commission Resources, Inc.

In 1987, the name of the organization was changed to the Joint Commission on Accreditation of Healthcare Organizations, because the agency's activities extended well beyond hospitals. Hospice accreditation, for example, was introduced in 1984. It was discontinued in 1990, but the hospice standards were brought back in the 1995 home care manual, resulting in the combination of hospice and home care under the home care program. Accreditation for home health agencies began in 1988, and accreditation for managed care organizations was introduced in 1989 but later discontinued. The home

Table 1. Overview of Accrediting Organizations

Accrediting Body	Target Areas for Accreditation	Types of Standards
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Hospitals, home health, long-term care, behavioral healthcare, clinical laboratories, ambulatory care, health networks	Structural, organizational, patient focused
National Committee for Quality Assurance (NCQA)	Managed care plans	Clinical, administrative
American Medical Accreditation Program (AMAP)	Physician credentials and office practices	Environment of care, credentials, patient outcomes, clinical process
American Accreditation HealthCare Commission/ Utilization Review Accreditation Commission (AAHC/URAC)	Managed care organizations (emphasis on preferred provider organizations and workers' compensation programs)	Credentials verification organization standards, workers' compensation, case management, health network, health utilization
Accreditation Association for Ambulatory HealthCare (AAAHC)	Ambulatory surgery, birthing centers, urgent care, community health centers,	Patient rights, governance, quality of care, environment,

care program is now the largest in terms of the number of agencies accredited.

By 1992, the JCAHO's Accreditation Manual for Hospitals began to emphasize standards that evaluate performance. Accreditation for healthcare networks began in 1994. That same year the JCAHO and Quality Healthcare Resources formed the Joint Commission International with the goal of serving international clients. In 1999, Joint Commission Resources replaced Quality Healthcare Resources and the Joint Commission International. Joint Commission Resources now includes Joint Commission Worldwide Consulting, concerned with domestic as well as international consulting, and Joint Commission International Accreditation, concerned with global accreditation. The latter organization conducts quality improvement interventions in various nations.[9]

Also in 1999, the JCAHO's board established the Public Advisory Group on Health Care Quality. This step emphasizes the JCAHO's stand on building relationships with patients, consumers, and their advocates. The activities of the Public Advisory Group include advising the JCAHO on health issues and quality evaluations relevant to the public, identifying significant outcomes, and refining performance reports.

Description

The nation's largest and oldest accrediting body, the JCAHO is an independent, not-for-profit organization that evaluates and accredits nearly 20,000 healthcare organizations and programs. The 28-member Board of Commissioners includes nurses, physicians, consumers, medical directors, administrators, providers, employers, a labor representative, health plan leaders, quality experts, ethicists, a health insurance administrator, and educators.[10] The Board of Commissioners now includes members of the public. The corporate members of the JCAHO include the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association.

Accreditation Programs, Processes, and Standards

The accreditation services of the JCAHO are available to almost 12,000 hospitals and home health agencies and more than 7000 organizations that provide behavioral healthcare, long-term care, ambulatory care, and clinical laboratory facilities. The JCAHO also accredits healthcare networks, integrated delivery networks, and other managed care organizations. Home care covers all types of patients needing home nursing, physical therapy, and other services, including terminally ill patients in a hospice setting. The JCAHO does not specifically accredit federally funded community health centers, unless they meet certain eligibility criteria. It does, however, accredit certain centers that provide ambulatory care.

In response to external pressures and to improve educational support, the JCAHO established the ORION project to test innovations in accreditation services in selected states.[8] The goal is to tailor performance measurement activities to the scope of services and data-gathering capability of individual organizations.[11] Quality Check™, available on the Internet, provides the accredited organization's name, telephone number, address, accreditation decision, accreditation date, current status, and effective date.[12] Performance reports, accessible through Quality Check, provide information about organizations that have undergone a JCAHO accreditation survey.

To earn and maintain accreditation, an organization undergoes an on-site survey by a JCAHO team at least once every 3 years. The healthcare network accreditation program involves a 3-level survey process. The first level is a survey of the central office, the second is a survey of a sample of unaccredited components as well as high- and low-risk services, and the third is a survey of practitioners' offices.[13] Once the accreditation survey is complete, the healthcare organization is granted either accreditation with commendation, accreditation, accreditation with type 1 recommendations, conditional accreditation, provisional accreditation, preliminary accreditation, or no accreditation.

The JCAHO evaluates an organization's performance in areas such as patient care and outcomes and organizational management. The emphasis is no longer on minimum standards but rather on standards that are functional and focused on patient care. The JCAHO hospital standards can be categorized as follows: (1) patient-focused functions, including patients' rights and organizational ethics, assessment of patients, care of patients, education, and continuum of care; (2) organizational functions, such as improving organizational performance, leadership, management of human resources, management of information, and surveillance, prevention, and control of infection; and (3) structures with functions, such as governance, management, and medical staff and nursing.[14]

Performance Measures

Performance measures help to determine whether a process, service, or function is in tune with the identified performance expectation; they also serve as statistical measures or benchmarks to facilitate comparison. In 1997, the JCAHO launched ORYX, which integrates performance measures into the accreditation process. The purpose of ORYX is to link accreditation and patient outcomes, thus working toward the goal of making the accreditation process more valuable, with a focus on patient care.[15] The healthcare organization undergoing accreditation chooses from the available performance measurement systems and selects 2 measures that are relevant to their situation. The number of required measures for hospitals, long-term care organizations, home care, and behavioral healthcare has now been increased from 2 to 6, to be submitted over a span of time.[15] ORYX Plus is a voluntary option, the requirements of which far exceed those of ORYX. It is used by organizations that intend to contribute to a national database. The JCAHO expects home health agencies to establish their own performance measures, which gives these organizations the freedom to develop their own quality assurance programs and outcome measures.[16]

Perspective

The JCAHO is known for its public perspective and attempts to maintain this image. "We need to focus our attention on the interests of those who are receiving care or will receive care in the future. That's the public in the broadest possible sense," says Dennis S. O'Leary, MD, president of the JCAHO.[17] Over the years, the JCAHO has been criticized by consumer advocates, payers, and the media for not being so public minded.[18,19] In 1999, the US Department of Health and Human Services' Inspector General recognized "significant strengths" amidst "major deficiencies" in JCAHO hospital surveys.[20] In response, the JCAHO now conducts unannounced and more stringent inspections.

·· NATIONAL COMMITTEE FOR QUALITY ASSURANCE ···

Mission

"NCQA's mission is to provide information that enables purchasers and consumers of managed healthcare [to] distinguish among plans based on quality, thereby allowing them to make more informed healthcare purchasing decisions."[21] The objective of the NCQA is to encourage plans to compete on the basis of "quality and value rather than price and provider network alone."[20]

History

The NCQA was formed in 1979 by large employers who purchase health maintenance organization services, managed care providers, and the Group Health Association of America. This thwarted the creation of a federal regulating system to evaluate managed care companies. Charges of underutilization of services due to cost constraint in managed care organizations propelled the formation of an independent body to evaluate different plans. In 1990, the NCQA became independent, aided by a grant from the Robert Wood Johnson Foundation. The NCQA began accrediting managed care organizations in 1991 and now accredits managed behavioral healthcare organizations and credentials verification organizations and physician organizations. The first performance measurement set, the Health Plan Employer Data and Information Set (HEDIS) 2.0, was released in November 1993. In 1995, the NCQA issued a technical update, HEDIS 2.5, and followed that with Medicaid HEDIS that included measures specific to the Medicaid population. HEDIS 3.0 was released in 1996, and HEDIS 2000 is now being rolled out.

Description

The NCQA is a private nonprofit organization dedicated to assessing and reporting on the quality of managed care plans. Fifty-three percent of the approximately 630 health maintenance organizations in the United States are involved in the NCQA's accreditation process.[21] The board of the NCQA was reconstituted after the organization became independent in 1990. The board now numbers 20 people and includes employer, consumer, and labor representatives, health plan representatives, quality experts, policy makers, and representatives from organized medicine.[20] Physicians and medical directors of managed care plans play an important role as members of the board. The main sources of funding for the NCQA have been the US Health Care Financing Administration, the Commonwealth Fund, the Henry J. Kaiser Foundation, the Robert Wood Johnson Foundation, and the David and Lucile Packard Foundation. Among pharmaceutical companies, Merck, Pfizer, and SmithKline Beecham have made significant contributions. The NCQA receives tremendous support from large employers, including Ameritech, General

Motors, General Electric, IBM, Ford, Bristol Myers Squibb, and Xerox. Employers use the NCQA as a tool to pressure health plans to raise their standards of quality for their employee populations.

Accreditation Programs, Processes, and Standards

The NCQA performs voluntary accreditation for managed care plans. Its accreditation process involves a rigorous survey to determine whether the managed care organization meets certain standards in key areas, such as the clinical and administrative systems of a health plan. Standards and performance measures are classified into the following categories: access and service, qualified providers, staying healthy, getting better, and living with illness.[20]

The NCQA's accreditation process involves an on-site and an off-site survey. The survey team consists of physicians and managed care experts. The final accreditation decision is made by a committee that consists of senior physicians from the managed care industry. The decision could be either excellent, commendable, accredited, provisional, or denied. The NCQA's Accreditation Status List provides the status of health plans that have been surveyed, have a decision pending, or have scheduled a survey. Accreditation Summary Reports are 2-page reports that indicate how well a plan performed on its survey and reveal a plan's strengths and weaknesses in the areas mentioned above. Because NCQA accreditation status is made public (and disseminated through the popular news media), many health plans have decided to participate, but withhold their data from public scrutiny.

Performance Measures

Performance measures for health plans have been developed using HEDIS. "Almost 90 percent of all health plans measure their performance according to the protocols defined by HEDIS on various aspects of care and services such as immunization rates, member satisfaction, and mammography rates," writes Margaret O'Kane, president of the NCQA.[22] HEDIS was developed in an attempt to standardize the way in which health plans calculate and report data about their performance. HEDIS 3.0 performance measures fall into 8 main areas: effectiveness of care, access and availability of care, satisfaction with the experience of care, health plan stability, use of services, cost of care, informed healthcare choices, and health plan descriptive measures. HEDIS 3.0 incorporates measures related to smoking cessation, member satisfaction, cancer screening, mammography, cardiovascular disease, diabetes, asthma, and other public health concerns.[23] HEDIS data are provided to consumers in the form of report cards. HEDIS also includes a member satisfaction survey, which provides comparable member satisfaction data from different health plans. HEDIS has been criticized for being overly concerned with preventive measures, so HEDIS 2000 will include measures for chronic conditions.

The program, "Accreditation '99" mentions critical consumer protection standards, which include preventing plans from limiting or denying care though the use of financial incentives, encouraging plans to approve exceptions to a restricted formulary, and coordinating medical and behavioral healthcare.[24] The JCAHO and NCQA have called for a national framework to ensure the confidentiality of patients' personal health information, which is believed to have a direct effect on quality of care. Accreditation '99 also incorporates selected measures from HEDIS, including those related to immunization rates, mammography rates, member satisfaction, access, service, and other areas of public concern.[24] The new standards are applicable to surveys of health plans conducted after July 1, 1999.

HEDIS 2000, developed with a view toward enhancing the evaluation of quality, will add measures specific to cardiac care, asthma, chlamydia, diabetes, and menopause. Some of the measures include controlling high blood pressure, cholesterol management after a heart attack, screening for chlamydia, counseling for hormone replacement therapy in menopause, and emergency room visits and medication measures in asthma.[25]

The NCQA's Quality Compass™ is a national database of HEDIS data and accreditation information. It has enabled the NCQA to generate national and regional averages and to identify benchmarks.[20] The Quality Compass is a source of information for employers, consultants, consumers, and health plans. A partnership with HCIA, Inc, a leading healthcare information company, was undertaken to promote the use of Quality Compass.[26]

The HEDIS Compliance Audit was created to address the variability in the way health plans collect and calculate HEDIS data and the methods used by auditors to verify such data. The audit has rendered HEDIS data comparable from plan to plan.[26] It consists of standardized auditing procedures and an auditor certification program to help ensure that the data meet NCQA standards.

The NCQA conducts consumer research to ensure that updates of HEDIS and Quality Compass are sensitive to the needs of consumers. A consumer brochure, "Choosing Quality: Finding the Health Plan That's Right for You" has been released by the NCQA. It outlines a simple 4-step process to help consumers use the information provided to them.[27] The brochure also provides an overview of the accreditation process and HEDIS.

The NCQA also reviews and certifies credentials verification organizations and other organizations that verify the credentials of physicians. As part of this certification program, the NCQA evaluates the processes involved in the organization's credentialing operations and methods to improve services.[28] Results of the evaluation of a credentials verification organization are made public.

Perspective

The NCQA accredits managed care plans and expects managed care companies to contract with accredited hospitals and other healthcare entities. The organization supports the idea of healthcare providers going through an external review rather than relying on an internal assessment only. The NCQA also is committed to public reporting of information related to healthcare quality and emphasizes the importance of physician involvement. "Physician involvement and awareness of our activities are essential. I feel strongly that NCQA's and the practicing physician's interest is in direct alignment," said Cary Sennett, MD, PhD, past executive vice president at the NCQA.[29] The unionization attempt by the American Medical Association against managed care, however, suggests differently.[30-32]

··· AMERICAN MEDICAL ACCREDITATION PROGRAM ···

Mission

"The AMAP serves to provide a consistent, credible, and convenient source of information on physician quality."[33] The objective behind the formation of the AMAP is to maintain a high quality of physician care.

History

The American Medical Association, in close collaboration with specialty, state, and local medical societies, developed the AMAP. The lack of any program to evaluate physician office practices prompted the need for such a program. In essence, physicians want to evaluate themselves and not let hospital administrators, managed care executives, or insurers do it.

Description

The AMAP is a voluntary, comprehensive accreditation program that evaluates physicians against national standards.[34] It facilitates the exchange of physician-to-physician information essential to continuing improvement and is the first nationally recognized program for individual physician quality accreditation. The AMAP's governing body and committees include experts representing physicians, organized medical societies, health plans and insurance companies, hospitals and health systems, employers and business coalitions, consumer groups, regulatory agencies, and accreditation organizations.[35]

Accreditation Programs, Processes, and Standards

An important aspect of the process of obtaining AMAP accreditation involves meeting the Environment of Care standard. This standard requires physicians to achieve an overall minimum score of at least 70% along with minimum section scores on the AMAP survey or have at least 75% of their practice in an office, clinic, group practice, or hospital accredited by an AMAP-recognized accreditation organization.[36] Accreditation conducted by other organizations is accepted by the AMAP if it is comparable to the Environment of Care survey. Individual physicians are evaluated against national standards, criteria, and peer performance in the following 5 areas: credentials, personal qualifications, environment of care, clinical process, and patient outcomes.[34]

The AMAP provides minimum standards, credentials verification, and office reviews. It also evaluates ethics (under personal qualifications), peer review, self-assessment, clinical performance, and patient satisfaction, thus combining several important processes into 1 accreditation program.

When a physician submits an application, the AMAP first verifies credential information with primary sources and then conducts an office site review. After completing its review, the AMAP provides an accreditation report and certificate to each physician who meets the standards. Information regarding the office review and verified credentials

is also provided to every health plan and hospital that uses the AMAP.

Perspective

The AMAP works closely with the American Board of Medical Specialties but is not a competitor or substitute for board certification. The AMAP invites collaboration from member societies of organized medicine.[35] "We believe the specialties have a lot to gain through participation in AMAP. They will have the opportunity to set the standards for their specialty instead of having them imposed by outside groups," says Dr. Timothy Flaherty, AMA Trustee.[37] The AMAP is a federation program, with the federation being involved in the implementation and design of the program. Dr. Flaherty adds, "If we are going to have a national acquisition of data about physicians and physician performance, it should be done by physicians, not the government, not the insurance companies."[37]

The JCAHO, the AMAP, and the NCQA have collaborated to form the 15-member Performance Measurement Coordinating Council (PMCC) to coordinate performance measurement activities across the entire healthcare system. The 3 accrediting organizations have been working in different spheres of performance measurement. The PMCC was formed to address the issue of overlapping and sometimes redundant accreditation processes that arose from competition between accrediting bodies. The PMCC will initially focus on the development of common criteria and processes for the creation of new performance measurement sets. In the future, it plans to create expert panels in specific clinical areas to guide subsequent performance measure development.

The goal of the PMCC is to render data collection useful to consumers and healthcare professionals alike and to ensure that the process of data collection and reporting is more efficient. It also addresses risk-adjustment issues, a critical factor in measuring the performance of both physicians and healthcare facilities.[38] The council is positive that its efforts will decrease the costs of data collection and reporting. This would probably be achieved by standardizing data requirements, reducing redundancy, and coordinating performance measurement activities. Negotiation between competing accrediting organizations, however, might become an arduous process in itself. Typically, without clear external pressures, a joint venture of this nature would not yield timely outcomes.

··· AMERICAN ACCREDITATION HEALTHCARE COMMISSION ···

Mission

The mission of the American Accreditation HealthCare Commission (AAHC) is to promote continuous quality improvement and establish standards for the managed care industry. It also supports programs aimed at education and communication.

History

The organization was formally chartered on February 14, 1990, as the Utilization Review Accreditation Commission, Inc. (URAC).[39] The name of the organization was changed in 1996 to the American Accreditation HealthCare Commission as a result of the expansion of programs intended to address a broad range of managed care activities.

Description

The AAHC is a 501(c)(3) nonprofit organization, the members of which represent providers, regulators, consumers, payers, and managed care entities.[39] Member organizations participate in the development of standards and are eligible to sit on the board of directors. The organization is the premier accreditation organization for preferred provider organizations and similar networks, utilization management organizations, and workers' compensation managed care programs. The AAHC has issued more than 1200 accreditation certificates to over 300 managed care organizations. Twenty-four states and the District of Columbia have incorporated AAHC accreditation into their regulatory processes.[39]

Accreditation Programs, Processes, and Standards

The AAHC offers the following 9 different accreditation programs for managed care organizations: case management organization standards, credentials verification organization standards, health call center standards, health network standards, health plan standards, health utilization management standards, network practitioner credentialing standards, workers' compensation network standards, and workers' compensation utilization management standards.[40]

The AAHC process involves submission of documentation indicating compliance with each standard. The accreditation staff also visits the site to verify that the actual standards observed are in keeping with the documentation. The accreditation commit-

tee reviews the application and a final decision is made by the executive committee, with the validity extending for 2 years from the time of approval.[41]

The special feature of the AAHC program is the flexibility of its "modular approach,"[40] which caters to the diversity of the market. Organizations can seek accreditation under different sets of standards, using each program separately or in combination with others, thus enabling them to tailor the accreditation process to the services they offer.

Perspective

The AAHC is open to public comment and has incorporated such feedback in revising its external review organization standards. In relation to this, Garry Carneal, AAHC President and CEO said, "We want to be certain that we thoughtfully consider all of the issues surrounding external review before the standards become final."[42] Historically, the AAHC never mobilized as wide a constituency of multiple players in the marketplace as did the JCAHO, the NCQA, and the AMAP. Consequently, the AAHC competes with the other accrediting bodies, which seem to have secured more of a monopoly in their respective areas of accreditation.

··· ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE ···

Mission

"The mission of the AAAHC is to assist ambulatory healthcare organizations in improving the quality of care they provide to their patients."[43] This mission is achieved through educational efforts, performance measurement, and the setting of standards.

History

The AAAHC was incorporated in 1979 in Illinois.[44] The activities of several national organizations over the past 25 years contributed to the existence of the AAAHC.

Description

The AAAHC is a private, nonprofit organization. Board members are appointed by 12 leading healthcare organizations, including the American Academy of Cosmetic Surgery, American Academy of Dental Group Practice, Association of Oral and Maxillofacial Surgeons, American College Health Association, Federated Ambulatory Surgery Association, Medical Group Management Association, and the Association of Freestanding Radiation Oncology Centers.[44] More than 1000 organizations are currently accredited by the AAAHC. These include ambulatory clinics, health maintenance organizations, and intermediate-level providers, such as ambulatory surgery centers, medical groups, single and specialty group practices, birthing centers, college and university health services, faculty medical practices, community health centers, Indian health centers, pain management clinics, and urgent and immediate care centers. Associations that make up the board and the organizations that undergo the accreditation survey contribute toward funding.

Accreditation Programs, Processes, and Standards

The survey team includes physicians and healthcare professionals familiar with the type of organizations the AAAHC accredits. Before an on-site survey, the organization is expected to conduct a self-assessment, using the standards outlined in the Accreditation Handbook for Ambulatory Healthcare. The following standards are used in the accreditation process: rights of patients, governance, administration, quality of care, quality management and improvement, clinical records, professional improvement, and facilities and environment.[44] The board of directors makes accreditation decisions, and accredited status is granted for 1 year or 3 years depending on the extent to which organizations comply with standards. Organizations must undergo surveys once every 3 years to maintain accreditation.

The AAAHC is actively involved in educating providers about quality care. The Physician Checklist for Ambulatory Surgery Centers, for example, provides a review of the life safety issues involved in a new ambulatory care facility. Patient rights also are of special importance to the AAAHC, which addresses areas of patient communication, grievance issues, appeals procedures, and consumer information.

Perspective

William Beeson, MD, president of the AAAHC, says, "It's one thing to offer standards that organizations must meet in order to achieve accreditation. But, as leaders in the accreditation arena, it's essential that we also provide our broad base of constituents a workable model for measuring perfor-

mance. They must have the proper benchmarks to allow them to achieve performance improvement."[45] Of note is that the AAAHC has been approved by the AMAP to provide Environment of Care surveys. Also, the Health Care Financing Administration (HCFA) as granted "deemed status" to the AAAHC for the purpose of certifying ambulatory surgical centers, meaning they meet HCFA standards for Medicare and Medicaid reimbursement.[46]

Yet for the most part, the AAAHC remains a tool of niche medical specialty practices. The quality measures it uses are unique to the specific organizations it accredits, which range from university clinics to surgical subspecialty or radiation therapy practices.

··· FOUNDATION FOR ACCOUNTABILITY AND THE AGENCY FOR HEALTH CARE RESEARCH AND QUALITY ···

Two other organizations, the Foundation for Accountability (FACCT) and the Agency for Health Care Research and Quality (AHRQ, formerly the Agency for Healthcare Policy and Research [AHCPR]), have been highly influential in developing standards and performance measures. The FACCT is dedicated to disseminating consumer-focused information. It was formed out of meetings by the Jackson Hole Group convened by Paul Ellwood, MD, and Alain Enthoven, PhD, after the failure of national health reform efforts in 1994. In September 1995, individuals representing consumer groups, government officials, and private employers developed a framework for performance measurement, and the first 5 quality measurement sets were published in June 1996.[47] A set of patient-based measures for the treatment and management of diabetes, major depressive disorder, breast cancer, customer satisfaction, and population health risk behaviors has also been developed by the FACCT.[48] The quality measures are meant to be relevant to the needs of consumers and buyers of healthcare. The FACCT does not actually conduct accreditation surveys but acts as an addendum by developing patient-focused measures.

The FACCT's Consumer Information Framework helps simplify information sharing, performance measurement, and education. The framework has 3 main components: (1) *messages,* which primarily focus on educating customers regarding the meaning of quality and the use of comparative information provided to them; (2) *model,* which analyzes and classifies comparative information into 5 categories: the basics, staying healthy, getting better, living with illness, and changing needs (the categories are differentiated on the basis of how consumers perceive their care); and (3) *measures,* which create scores for the above categories belonging to the model as well as condition-specific performance scores.[49]

A variety of sources are used to create weights and scores, some of which include the NCQA's HEDIS, the FACCT measurement sets, the AHRQ's Consumer Assessment of Health Plans Survey, and public health databases.[49] The FACCT emphasizes that patients and consumers play as important a role as providers do in improving the quality of care. It strives to educate consumers and use them as a market force to influence quality in healthcare. The FACCT seeks to create a healthcare system in which consumers can make better choices, and along with employers, theoretically serve to hold the system accountable.

The AHRQ is part of the Public Health Service in the US Department of Health and Human Services[50] and directs its efforts toward enhancing quality improvement and cost containment. The Agency is well known for developing evidence-based clinical practice guidelines. It also funds research in the evaluation of cost effectiveness and medical outcomes in different clinical interventions.

The AHRQ was created by Congress in 1989 in response to a recommendation from the Physician Payment Review Commission.[50] This group opined that changes in the way physicians were rewarded would encourage high quality care. However, the move toward managed care raised some new questions. Consequently, the AHRQ targeted the following areas: clinical improvement; healthcare cost, financing, and access; outcomes and effectiveness of healthcare; and measurement and evaluation of quality.

CONQUEST 1.1 (COmputerized Needs-oriented QUality measurement Evaluation SysTem) is the AHRQ's database of existing performance measures. CONQUEST was developed by the AHRQ in a joint project with the AMA and the American Association of Health Plans, which maintains an online database of existing guidelines. An important achievement of the AHRQ was the Consumer Assessment of Health Plans Survey, which is used to evaluate consumer response and preferences.[51]

The AHRQ funding of clinical guideline development and its work in stressing quality improvement

increased awareness of healthcare quality among patients and managed care organizations alike. The Agency, however, no longer focuses on clinical guidelines. With its new name and changed mission, the Agency for Health Care Research and Quality now focuses largely on quality.[52]

··· DISCUSSION ···

Quality of care is a much-discussed issue by all stakeholders in the healthcare system. Nevertheless, it remains little understood in both concept and measurement, even by medical professionals.[53] For decades, some of the best minds in healthcare have struggled to formulate a concise, meaningful, and applicable definition of quality of care.[54] Most often, quality of care is defined simply as some intangible, hard-to-grasp abstract. Such expressions largely ignore the fact that the basic concepts for quality of healthcare were established by Avedis Donabedian more than 3 decades ago.[55]

Donabedian's constructs of structure, process, and outcome remain intact, but the present flurry of activity focuses on the historical dilemma of identifying measurable outcomes. Structural determinants of quality, initially heralded most by the JCAHO, were supplanted by advocacy for and many studies on process indicators. Within this direction, high quality of care became synonymous with technical excellence, where the appropriate service was delivered with professional skill.[54] The pursuit of technical excellence and its equation with "high quality" ideologically supported the ongoing medical arms race of the 1960s and 1970s among academic medical centers supported by the National Institutes of Health and a corporate array of pharmaceutical, medical device, and other technology companies.[56,57] Medical education took up the banner of striving for technical excellence, and the public began to expect such when obtaining care. The resulting technologic environment of healthcare in the United States has tended to neglect the patient as a person, downplaying the mind and the spirit.[58] Technical excellence removed patients from their social and cultural experience and objectified them as a disease entity.

Rereading Donabedian, we discover that he stressed the importance of a balance between technical care and social responsibility.[59] High quality of care, according to Donabedian, was "that kind of care which expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all of its parts."[59] Nowadays, the patient's perspective is being incorporated into almost every quality measure as we recognize that outcomes are crucial to assessing the performance of today's healthcare organizations and linking them to cost effectiveness. Even pharmacoeconomists in the employ of the pharmaceutical industry strive in such a direction for quality-of-life measures.

By the late 1960s and early 1970s, Corporate America wholeheartedly embraced continuous quality improvement and total quality management, mimicking Japanese ideas in quality management.[60] Genichi Taguchi originated his famous "robust" design, using engineering techniques to identify and minimize the effects of variation on product quality.[61] Kaoru Ishikawa simplified statistical techniques for quality control and developed some fundamental quality control concepts. As the theory and methodology of continuous quality improvement took hold across Corporate America, it was also found applicable to healthcare. The implementation of continuous quality improvement requires team participation, a fundamental aspect in the accreditation process. Good management is always the key to improved performance.[62] The accrediting process was thus acclaimed to provide opportunities for health administrators and professionals to improve the quality of their healthcare services. Six Sigma, the current craze in corporate quality circles, stresses training in the measurement sciences, business analysis, and achieving bottom-line results, all applicable to the healthcare sector in the 1990s and today.[63]

Yet the same corporate leaders attempting to improve quality control in their own production processes simultaneously began an unprecedented examination of American healthcare,[64] warranted because they pay for premiums in worker's health benefit packages. Employee benefits managers raised the question of what "value" they receive for their financial outlays.[65] Clearly, the structural and process indicators gathered under past accreditation processes would not suffice as better accountability measures were sought by business leaders.

From the late 1980s on, the nation's healthcare system entered what Relman calls "the era of assessment and accountability."[66] More serious attempts to measure quality of care are now under way, and the dissemination of quality information is believed to be the solution for the quality problem. More so than ever, external reviewers are aggressively requesting the demonstration of high quality care,

and healthcare practitioners will be more than ever scrutinized, compared with standards and peers, and made known to the general public in report cards.[67]

Information seems to be a powerful tool to improve the quality of healthcare provided today. In theory, informed consumers can help solve present-day healthcare issues. If a superior plan gets more members and resources, other plans will be pressured to raise their standards. Public reporting of the quality of health plans does help consumers to choose using the information provided. *Newsweek's* annual survey evaluated plans in 3 areas: keeping members healthy, treating acute illness, and managing chronic illness for adults and children.[68] In addition, the survey reported whether the plan had received accreditation from the NCQA. Other public media publish rankings of health plans and offer informational aids for consumers.

The organizational time and financial cost required for undergoing accreditation are serious issues for healthcare organizations today. For many hospitals, accreditation can be a grueling experience; the visit by the accrediting team seems more of an experience to survive for financial reimbursement, rather than a transition to enhanced quality. Because of the high cost of preparing for JCAHO accreditation, a few hospitals around the country may drop this in favor of the ISO 9000 standard, an accreditation usually used in manufacturing. The American Legion Hospital in Crowley, Louisiana, is one such hospital.[69,70] The ISO 9000 may be seen more as a complement, however, because it still cannot replace approval for a hospital's "deemed status" by the Health Care Financing Administration. The latest ISO 9000 series with its 3 standards (ISO 9000:2000, ISO 9001:2000, and ISO 9004:2000) reveals a primary focus on customer-related processes and continual improvement, with less emphasis on manufacturing components.[71] This new direction seems relevant to the current situation in healthcare.

Certain healthcare organizations involved in various accreditation programs have experienced problems stemming from the continuous change in the nature of standards, nomenclature, and processes related to accreditation.[72] In this age of discontent among consumers, payers, and professionals, it remains a challenge for most accrediting bodies to bring together varying and sometimes conflicting interests.

In the 1980s, it was thought that local business coalitions might act on their own to improve quality in the healthcare facilities to which they sent their employees. The Cleveland Health Quality Choice was one such effort; purchasers demanded information from area hospitals on quality and cost and made it public, showing patient satisfaction levels and death rates for a range of illnesses.[73] This initiative had a clear impact on physician practices, but the effort was disbanded in 1999. Other employers and insurance companies still channel employees (patients) to lower cost and higher quality providers, but the number of prudent buyers in the healthcare marketplace has not reached what some analysts expected by now.

At its outset, the NCQA responded to business payer interests by delineating outcomes. HEDIS 2000, although following a logical progression in the regulatory process, now challenges health maintenance organizations to demonstrate outcomes in difficult chronic illnesses. Increasing the rate of preventive screening utilization is one thing, but improving the clinical status of the elderly and disabled is a far greater accomplishment. The JCAHO chose a more politically palatable path by allowing hospitals to choose their own outcome measures rather than reveal that most institutions might miss the mark if it was set too high and too fast.

One fact that cannot be easily overlooked is that accreditation, as with most regulatory processes, can be manipulated, and critics have charged that it is often a tool used to "game the system" by various players in the healthcare industry. In this new era of accountability, we need to ask to what extent accrediting organizations are truly guaranteeing high quality and cost-effective services throughout the United States. Their processes must be shown to both differentiate providers and to improve all those found below standards.

··· CONCLUSION ···

The current emphasis on cost containment has affected both the quality and quantity of medical care provided in the United States. The banner of quality improvement was taken up when business and government purchasers of care voiced concerns about the value received for their financial outlays. These concerns have been partially addressed by the creation and functioning of additional accrediting bodies. Although in some quarters skepticism still reigns, purchasers and consumers alike have felt the need for accreditation and have generally supported it. This demand has forced health main-

tenance organizations and integrated healthcare networks to be more diligent in seeking full-term accreditation. The future holds a great say for purchasers in influencing providers' business practices, information management, and even disease state management for specific populations.

With the increased emphasis given to performance measures, and for these measures to be made public, accreditation provides an opportunity for healthcare organizations that perform self-assessments on their patient-based functions to demonstrate performance improvements. In turn, accrediting bodies should recognize the increased diversion of diminishing resources from actual patient care activities to the quality enhancement process. Despite the difficulties associated with accreditation, healthcare organizations will be continually pressured to go through the accreditation process for competitive advantage. We hope that accreditation can truly find ways to institute quality improvement at deepening levels, rather than just be a matter of financial survival.

··· ACKNOWLEDGMENT ···

We thank SwuJane Lin, PhD (cand.), and Anne Rooney, MSN, MPH, for invaluable comments on an earlier draft. Feedback from *The American Journal of Managed Care* editors and reviewers is also appreciated. The authors retain sole responsibility for the information presented here.

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